



Regence

1800 Ninth Avenue
PO Box 91015
Seattle, WA 98111-9115



Regence BlueShield serves select counties in the state of Washington
and is an Independent Licensee of the Blue Cross and Blue Shield Association

VISION CLAIM FORM

Use this form to submit reimbursement requests for services from a non-network provider or for the purchase of prescription contact lenses or eyeglasses. Please complete a separate form for each family member. The time limit for filing claims is one year from the date of service/purchase.

Note: This form may be used for claims for Uniform Medical Plan, UMP Classic, UMP CDHP, or UMP Plus. Most providers will bill directly and no claim form will be necessary. However, if you do incur expenses from a provider that does not bill the plan directly, you will need to complete sections 1, 2 and 5 of the claim form. Have your provider complete sections 3 and 4 (Physician or Supplier information) unless the itemized bill(s) include this information.

1. Complete the information below and on the back of this form.
2. Attach itemized bills, including patient's name, date of service, diagnosis, procedures and charges.
3. Retain copies for your records. Receipts will not be returned.
4. Sign the completed form where indicated at the bottom of this page and submit the completed claim form to:

Regence BlueShield
Attn: UMP Claims
PO Box 1106
Lewiston, ID 83501-1106
Or by fax to: 1-877-357-3418

Payments will be mailed to the address on file for the subscriber. You can verify your address by calling UMP Customer Service at 1-888-849-3681.

1. EMPLOYEE/RETIREE INFORMATION		2. PATIENT INFORMATION	
UMP Identification Number (include alpha characters)			
Patient's Last Name		Patient's First Name	MI
Patient's Date of Birth	Patient's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse OR certified domestic partner (DP) <input type="checkbox"/> Dependent	Daytime Phone Number
Subscriber's Last Name		Subscriber's First Name	MI
Group Name Uniform Medical Plan		Group Number	
3. EXAMINING PHYSICIAN OR OPTOMETRIST INFORMATION			
Date of Service	Services Rendered	Refraction Included? <input type="checkbox"/> Yes <input type="checkbox"/> No	Charge
Physician's or Optometrist's Name, Address and ZIP code		Diagnosis code	Procedure code
		Telephone Number	
Signature of Physician or Optometrist ▶		Date Signed	

4. SUPPLIER INFORMATION (To be completed by provider or attach a copy of the prescription)**All sections must be fully completed before this claim will be processed or attach a copy of the prescription.**

Lenses for <input type="checkbox"/> One Eye <input type="checkbox"/> Both Eyes	Date Ordered	Date Delivered
Glasses: <input type="checkbox"/> One Pair <input type="checkbox"/> Two Pair		
<input type="checkbox"/> Single Vision \$ _____	Special Features: Yes No (Extra Charge, if any)	Frames: <input type="checkbox"/> Existing \$ _____
<input type="checkbox"/> Bifocal \$ _____	Plastic Lenses <input type="checkbox"/> <input type="checkbox"/> \$ _____	<input type="checkbox"/> New \$ _____
<input type="checkbox"/> Trifocal \$ _____	Oversize <input type="checkbox"/> <input type="checkbox"/> \$ _____	<input type="checkbox"/> _____
<input type="checkbox"/> Lenticular \$ _____	Tinting (of any kind) <input type="checkbox"/> <input type="checkbox"/> \$ _____	
<input type="checkbox"/> _____ \$ _____	Blended focal <input type="checkbox"/> <input type="checkbox"/> \$ _____	
	Other _____ <input type="checkbox"/> <input type="checkbox"/> \$ _____	
Aphakic? <input type="checkbox"/> Yes <input type="checkbox"/> No		TOTAL CHARGES (Including tax): \$ _____

Contacts: Therapeutic? <input type="checkbox"/> Yes <input type="checkbox"/> No			Aphakic? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Daily Wear Spherical Lenses		Daily Wear Toric		Flexible Wear	
<input type="checkbox"/> Hard \$ _____	<input type="checkbox"/> Soft \$ _____	<input type="checkbox"/> Soft \$ _____	<input type="checkbox"/> Soft \$ _____	<input type="checkbox"/> Soft \$ _____	<input type="checkbox"/> Soft \$ _____
<input type="checkbox"/> Gas Permeable \$ _____	<input type="checkbox"/> Gas Permeable \$ _____	<input type="checkbox"/> Gas Permeable \$ _____	<input type="checkbox"/> Gas Permeable \$ _____	<input type="checkbox"/> Gas Permeable \$ _____	<input type="checkbox"/> Gas Permeable \$ _____

Other \$ _____

Supplier's Name, Address and ZIP Code	Tax ID Number (TIN)
	Telephone Number
Signature of Physician or Optometrist	NPI
	Date Signed

5. EMPLOYEE/RETIREE RELEASE INFORMATION**Employee/Retiree/Patient/Authorized Person's signature (read before signing). I authorize the release of any medical information necessary to process this claim from my provider of service or any insurance company involved in final benefit determination.**

If allowed by the participating Blue Cross or Blue Shield Plan, I direct payment to be made to:

☐ The provider of service ☐ The employee/retireeSignature  _____ Date _____

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance.